STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

MARKET CONDUCT EXAMINATION

and

FINANCIAL AND COMPLIANCE EXAMINATION

OF

THE TENNCARE OPERATIONS

OF

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

d/b/a UnitedHealthCare Community Plan

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2013
THROUGH DECEMBER 31, 2013

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TN Department of Commerce & Insurance

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DATE: July 13, 2015

The Financial and Compliance Examination and Market Conduct Examination of the TennCare Operations of UnitedHealthcare Plan of the River Valley, Inc., Brentwood, Tennessee, was completed October 23, 2014. The report of this examination is herein respectfully submitted.

I. FOREWORD

On March 21, 2014, the TennCare Oversight Division of the Tennessee Department of Commerce and Insurance (TDCI) notified representatives of the TennCare operations of UnitedHealthcare Plan of the River Valley, Inc., (UPRV) d/b/a UnitedHealthcare Community Plan of its intention to perform a market conduct examination and a financial statement and compliance examination. Fieldwork began on July 14, 2014, and ended on October 23, 2014.

This report includes the results of the market conduct examination "by test" of the claims processing system for UPRV's TennCare operations. Further, this report reflects the results of an examination of financial statement account balances as reported for TennCare operations by UPRV. This report also reflects the results of a compliance examination for its TennCare operations of UPRV's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of the TennCare operations of UPRV was conducted by TDCI under the authority of Section 2.25 of the Contractor Risk Agreements (CRAs) for the East, Middle, and West Tennessee Grand Regions between the State of Tennessee and UPRV, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-115 and § 56-32-132.

UPRV is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

As of financial statement date December 31, 2011, the Illinois Department of Insurance conducted a full scope financial examination of UPRV because the company is domiciled in Illinois. The Tennessee Department of Commerce and Insurance received and accepted Illinois' Report of Examination dated August 22, 2013. As a result, this division focused on selected balance sheet accounts and the TennCare income statement as reported for UPRV's TennCare operations submitted with its National Association of Insurance Commissioners (NAIC) Annual Statement as of December 31, 2013, and the Medical Loss Ratio Reports for the East, Middle, and West Tennessee Grand Regions as of December 31, 2013.

The current market conduct examination by TDCI focused on the claims processing functions and performance of UPRV's TennCare operations. The testing included an examination of internal controls surrounding claims adjudication, claims

processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The compliance examination focused on UPRV's TennCare provider appeals procedures, provider agreements, subcontracts, the demonstration of compliance with non-discrimination reporting requirements, and other relevant contract compliance requirements.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that UPRV's TennCare operations were administered in accordance with the CRAs and state statutes and regulations concerning HMO operations, so that UPRV's TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether UPRV met certain contractual obligations under the CRAs and whether UPRV was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-101 *et seq.*;

- Determine whether UPRV had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether UPRV's TennCare operations properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether UPRV's TennCare operations implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether UPRV corrected deficiencies outlined in prior TDCI examinations of UPRV's TennCare operations.

III. PROFILE

A. Administrative Organization

UPRV is a wholly owned subsidiary of UnitedHealthcare Service Company of the River Valley, Inc. (USCRV). USCRV performs all administrative functions of UPRV through an administrative services agreement between UPRV and USCRV. USCRV is a wholly owned subsidiary of UnitedHealthcare, Inc. which in turn is a wholly owned subsidiary of United HealthCare Services, Inc. (UHS). UHS is a wholly owned

subsidiary of UnitedHealth Group Inc. which is a publicly held company trading on the New York Stock Exchange.

In addition to TennCare operations, UPRV has Medicare and commercial lines of business in Tennessee, as well as in other states.

The officers and directors or trustees for UPRV at December 31, 2013, were as follows:

Officers for UPRV

Steven Craig Walli, President, Commercial
Scott Andrew Bowers, President, Medicaid Division
Robert Worth Oberrender, Treasurer
Christina Regina Palme-Krizak, Secretary
James Wesley Waters, Chief Financial Officer
Tracey Irene McLoone, M.D., Chief Medical Officer
Nyle Brent Cottington, Assistant Treasurer
Michelle Marie Huntley, Assistant Secretary

Directors or Trustees for UPRV

Cathie Sue Whiteside	James Edward Hecker
William Kenneth Appelgate, PhD.	Steven Craig Walli
Tracey Irene McLoone, M.D.	Scott Edward Williams
James Wesley Waters	Scott Andrew Bowers

B. Brief Overview

UPRV has served TennCare enrollees in the East Tennessee Grand Region since the inception of the TennCare program in January 1994 under the CRA between UPRV, formerly John Deere Health Plan, and the TennCare Bureau.

For the Middle Tennessee Grand Region effective April 1, 2007, the West Tennessee Grand Region effective November 1, 2008, and the East Tennessee Grand Region effective January 1, 2009, UPRV is contracted through an at-risk agreement with the TennCare Bureau to receive monthly capitation payments based on the number of enrollees assigned to UPRV and each enrollee's eligibility classification.

For the period January 1, 2013, through December 31, 2013, UPRV received 63% of its nationwide revenue and 75% of its Tennessee revenue from payments for providing TennCare covered services to members. As of December 31, 2013, UPRV had approximately 196,200 TennCare members in the East Tennessee Grand Region, 198,200 in the Middle Tennessee Grand Region and 174,700 in the

West Tennessee Grand Region. The TennCare benefits required to be provided by UPRV are:

- Medical
- Behavioral health
- Vision
- Long-term care ("CHOICES" program)
- Non-emergency transportation services

C. Claims Processing Not Performed by UPRV

During the period under examination, UPRV subcontracted with the following organizations for the provision of specific TennCare benefits and/or the processing and payment of related claims submitted by providers:

- March Vision Care Group, Inc., for vision, and
- United Behavioral Health, Inc., (UBH) a related party to UPRV, for behavioral health services.

The TennCare Bureau has contracted with other organizations for the provision of most dental and pharmacy benefits; therefore UPRV is not responsible for providing these services to TennCare enrollees. UPRV is required to maintain an agreement with the pharmacy benefits manager (PBM) for the purpose of making payment to the PBM on behalf of TennCare for TennCare covered services. UPRV is not at risk for payments made to the TennCare contracted PBM. In addition, UPRV is required to coordinate with the PBM as necessary to ensure that members receive appropriate pharmacy services without interruption.

IV. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comments to each finding can be found in Sections V, VI, and VII of this examination report:

A. Financial Deficiency

Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages.

(See Section V. C. of this report)

B. Claims Processing Deficiencies

1. UPRV failed to achieve the monthly claims payment accuracy requirement of 97% as required by Section 2.22.6 of the CRAs for the following months and claim types: East Tennessee Medical for the month of October 2013, East Tennessee Long-term Care for the month of September 2013, Middle Tennessee Long-term Care for the month of November 2013 and West Tennessee Long-term Care for the month of November 2013.

   (See Section VI.C.1. of this report)

2. The review of UPRV's claims payment accuracy reporting and testing procedures for December 2013 noted the following deficiencies:

   - Section 2.22.6.4.5 of the CRAs requires UPRV to determine if the allowed payment agrees with the contracted rate. UPRV's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

   - For two of the twenty claims tested, the amount paid by UPRV could not be verified against the reimbursement terms of the provider agreements.

   - For the twenty claims selected for testing, two paid claims were never submitted to TennCare as encounter data as required by Section 2.12.9.34.2 of the CRAs.

   (See Section VI.C.5. of this report)

3. The CRAs include additional monthly focused claims testing requirements for UPRV to self-test the accuracy of claims processing based on claims selected by TDCI. For the 900 claims tested for calendar year 2013, UPRV reported at least one attribute error on 91 claims.

   (See Section VI.D.1. of this report)

4. During the review of the errors identified as a result of focused claims testing, TDCI noted the following significant claims processing system issues:

   a. UPRV indicated that two claims were incorrectly denied during the January 2013 focused testing for the same reason. UPRV noted for one claim the system was incorrectly applying claims coding billing rules and the system error had been fixed. For the other claim, UPRV indicated that additional research found that the initial response to the focused testing was incorrect. The claim had been correctly denied for claims coding rules.

   b. UPRV indicated that three claims incorrectly denied for "submitted after provider's filing limit". The members were made retroactively eligible and the

claims should have paid. UPRV indicated that the claims have been sent for adjustment.

c. UPRV indicated that one claim incorrectly denied with denial reason "Medicaid ID number/disclosure needed". UPRV indicated that there was a disclosure ID on file and the claim should have paid. The claim was sent for adjustment.

(See Section VI.D.2. of this report)

5. During the review of focused claims testing results, TDCI noted the following additional items:

   a. Multiple claims were denied with the only denial reason communicated to the provider being "claim lacks needed information" or "payment adjustment submission/billing error". These are vague denial explanations and do not provide enough information for the provider to correct the claim. This finding is repeated from the previous examination report.

   b. UPRV does not submit all paid claims to the TennCare Bureau for encounter data purposes. The following discrepancies were noted:

      - Multiple paid claims were not submitted to TennCare since the claims failed compliancy edits. Encounter data for all paid claims should be submitted to TennCare.

      - Multiple paid claims where another payer or Medicare was the primary insurer were not submitted.

   c. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of UPRV's monthly focused claims testing.

      - UPRV communicates the procedure code and the modifier to the EVV system based upon the enrollee's plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee's plan of care.

      - The authorizations granted in UPRV's claims processing system are not always in agreement with the authorizations loaded in the EVV system. As a result of the error, providers are able to provide and bill for services not in agreement with the enrollee's plan of care.

      - For Home and Community Based Services (HCBS) claims, UPRV routinely communicates a second denial reason or explanation to the provider "claim may be covered by COB". This is not an appropriate denial reason since CHOICES HCBS claims would never be covered by other insurance.

- In completing the attribute test work for the monthly focused claims testing UPRV often indicated adjustments were required to correct a claim, however, illogically UPRV indicated no error was reported for any of the testing attributes.

d. TDCI noted the following issues in relation to the accuracy of the prompt pay data file submissions from which the samples of claims for focused testing were selected:

- Multiple claims were submitted with a status of "denied" and zero dollars paid; however, the explanation code indicated that the charges have been paid by another payer. UPRV should have marked these as "paid" claims, even though there was no UPRV liability after the primary insurer paid.

- Multiple claims were incorrectly reported as "paid" or "denied" rather than as "adjusted". UPRV agreed that the claims should have been reported as adjusted.

e. Multiple claims were denied for "date of service after the subscriber termination". UPRV's claim system assigns a new member number any time a member is reassigned to another Grand Region. The denial reason is inaccurate as the member was never terminated as a TennCare enrollee.

f. Testing resubmitted claims that were denied for timely filing found that the original claims were denied for missing Medicaid ID/TennCare disclosure. UPRV indicated that, per timely filing standard operating procedures (SOP), if a claim was originally denied for this reason, the timely filing requirement can be overridden when the claim is resubmitted after the appropriate disclosure is made. In violation of UPRV's SOP, the claims tested had continued to be denied in error for exceeding the timely filing limit.

g. Focused testing revealed that denied service lines of claims processed by the subcontractor, March Vision, were not submitted to TennCare for encounter data purposes.

(See Section VI.D.3. of this report)

6. Verification of UPRV Self-reported Focused Testing Results

a. TDCI noted during the review of the procedures utilized by UPRV when testing the attribute "Payment agrees to provider contracted rate", UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract.

b. During the review of the 35 claims for which no errors were reported by UPRV, TDCI could not verify that one claim paid at the correct reimbursement rate because the executed provider agreement could not be located.

c. During the review of the 91 claims reported by UPRV to have processing errors, TDCI noted 38 of the 91 claims were never reprocessed to correct the errors. UPRV provided the following explanations during fieldwork as to why these claims were not reprocessed:

- After submitting the focus testing results, UPRV later determined that 24 claims noted as processed in error were in fact processed correctly.

- Five claims were not reprocessed because there was either no financial impact or the financial impact was immaterial. As a result, the processing errors were not corrected.

- Nine claims had not been corrected at the time of fieldwork even though UPRV agreed that these claims should have been reprocessed.

UPRV should more carefully review responses to monthly focused claims testing results prior to submission of the report to TDCI. Claims found to be processed in error should be promptly corrected.

(See Section VI.D.4. of this report)

7. Copayment test work revealed that UPRV incorrectly applied a $500 copay to one member. Based on the member's TennCare eligibility status no copay should have been taken for this member.

(See Section VI.E. of this report)

C. Compliance Deficiencies

1. One provider complaint was resolved in 127 days. Tenn. Code Ann. § 56-32-126(b)(2)(A) requires UPRV to respond to a provider's reconsideration requests within 60 calendar days unless a longer time to completely respond is agreed upon in writing by the provider and the HMO. UPRV did not have a written agreement with the provider that the resolution of this complaint would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A).

(See Section VII.A. of this report)

2. The following deficiencies were noted during the testing of provider agreements:

- Two executed provider agreements were not based on template agreements prior approved by TDCI. These provider agreements had been submitted to and disapproved by TDCI. UPRV should not execute provider agreements on templates not approved by TDCI in violation of TCA § 56-32-103 and CRA section 2.12.2.

- UPRV resubmitted one of the two executed provider agreements not on prior approved templates; however, TDCI again disapproved it because it failed to meet CRA provider agreement requirements. UPRV has not resubmitted the agreement to TDCI for approval.

(See Section VII.E. of this report)

3. The following deficiencies were noted during testing of subcontracts:

   a. UPRV received, as required, prior approval for a subcontract template; however, UPRV executed a version different from the template prior approved by TDCI.

   b. A subcontractor and affiliate of UPRV further subcontracted with two additional companies to perform subrogation services. The UPRV affiliate did not receive prior written approval from UPRV and the TennCare Bureau before entering into the subcontracts thereby violating Sections 2.26.2, 2.26.3, and 2.26.1.4 of the CRA.

   (See Section VII.G. of this report)

V. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UPRV is required to file annual and quarterly financial statements in accordance with NAIC guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UPRV meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

As of December 31, 2013, UPRV reported $1,093,654,951 in admitted assets, $580,253,821 in liabilities and $513,401,130 in capital and surplus on the 2013 Annual Statement submitted March 1, 2014. UPRV reported total net income of $152,048,836 on the statement of revenue and expenses. The 2013 Annual

Statement and other financial reports submitted by UPRV can be found at www.tennessee.gov/commerce/tenncare/mcoreports.shtml .

1. Capital and Surplus

Tenn. Code Ann. § 56-32-112(a)(2) requires UPRV to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-112(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee for the provision of health care services to TennCare enrollees are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Section 2.21.6.1. of the CRAs requires UPRV to establish and maintain the minimum net worth required by TDCI, including but not limited to Tenn. Code Ann. § 56-32-112.

To determine the minimum net worth requirement as of December 31, 2013, TDCI utilized the greater of (1) the total annual premium revenue earned as reported on the NAIC Annual Statement for the period ending December 31, 2013, or (2) the total payments made to UPRV by the TennCare Bureau for 2013 plus premium revenue from non-TennCare operations.

(1) For the period ending December 31, 2013, UPRV reported total company premium revenues of $4,071,793,010, on the 2013 NAIC Annual Statement.

(2) UPRV received total payments from the TennCare Bureau of $2,571,670,895, and premium revenue from non-TennCare operations of $1,504,014,281, for a total of $4,075,685,176.

Utilizing the greater amount of $4,075,685,176 as the premium revenue base, UPRV's minimum net worth requirement as of December 31, 2013 is $64,885,278 ($150,000,000 x 4% + ($4,075,685,176-150,000,000) x 1.5%). UPRV's reported net worth at December 31, 2013, of $513,401,130 was $448,515,852 in excess of the minimum required.

2. Restricted Deposit

Tenn. Code Ann. § 56-32-112(b) requires HMOs to establish a restricted deposit and defines the calculation of the deposit based upon annual premium revenue. UPRV's required restricted deposit for the year ended December 31, 2013 is $18,350,000. However, Section 2.21.6.4. of the CRAs requires MCOs to have on deposit an amount equal to the calculated minimum net worth requirement. In addition the CRAs state:

> TDCI shall calculate the amount of the increased restricted deposits based on the CONTRACTOR's TennCare premium revenue only unless this calculation would result in restricted deposits below the statutory requirements set forth in Tenn. Code Ann. 56-32-112 related to restricted deposits; in which case the required amount would be equal to the statutory requirement as it is calculated by TDCI.

Utilizing only the TennCare premiums for calendar year 2013 of $2,571,670,895, UPRV's required restricted deposit based on Section 2.21.6.4 of the CRAs does not result in a restricted deposit below the statutory requirements set forth in Tenn. Code Ann. § 56-32-112. UPRV's required restricted deposit as of January 1, 2014, is $42,325,063. UPRV had on file with TDCI as of March 2014, safekeeping receipts totaling $44,100,000.

3. Claims Payable

As of December 31, 2013, UPRV reported $398,807,155 claims unpaid on the 2013 NAIC Annual Statement. Of the total claims unpaid reported, $265,427,549 represented an estimate for TennCare operations. This amount was certified by a separate statement of actuarial opinion. Review of the triangle lag payment reports after December 31, 2013, through September 30, 2014, for dates of services before January 1, 2014, determined that the reported claims payable for TennCare operations was adequate.

B. TennCare Operating Statements

Sections 2.30.14.3.3 and 2.30.14.3.4 of the CRAs require each submission of NAIC financial statements to contain a separate income statement detailing the quarterly and year-to-date revenues earned and expenses incurred as a result of participation in the TennCare program.
No deficiencies were noted in the preparation of the TennCare Operating Statements. The TennCare Operating Statements are separate schedules in UPRV's 2013 NAIC Annual Statement which can be found at www.tennessee.gov/commerce/tenncare/mcoreports.shtml.

C. Medical Loss Ratio Report

Section 2.30.16.2.1 of the CRAs requires:

> The CONTRACTOR shall submit a Medical Loss Ratio Report monthly with cumulative year to date calculation. The CONTRACTOR shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the CONTRACTOR, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The CONTRACTOR shall also file this report with its NAIC filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings including the supplemental TennCare income statement. The CONTRACTOR shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the CONTRACTOR's encounter file submission as specified in Sections 2.30.18.3 and 2.23.4.

The medical loss ratio (MLR) reports as submitted on January 21, 2014, for the period ending December 31, 2013, originally reported MLRs of 85.11% for the East Tennessee Grand Region, 84.77% for the Middle Tennessee Grand Region, and 84.87% for the West Tennessee Grand Region. TDCI reviewed the MLR reports for the same period ending December 31, 2013, but submitted on October 19, 2014. UPRV reported adjusted MLRs of 82.89% for the East Tennessee Grand Region, 82.47% for the Middle Tennessee Grand Region, and 83.67% for the West Tennessee Grand Region. The reason for the noted decrease in MLR percentages is due to adjustments of incurred but not reported (IBNR) estimates. Over time the IBNR estimates are reduced with the submission and payment of actual claims.

The procedures and supporting documents to prepare the MLR were reviewed. TDCI selected December 2013 as a test month. The following deficiencies were noted during the review of documentation supporting the amounts reported on the MLR:

> Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages. These administrative costs include:
>
> - Services related to detection of Audit Recovery Fee Payments to a Subcontractor,
>
> - Services related to detection of Fraud and Abuse Fee Payments to a Subcontractor.

Although the effect is immaterial, UPRV should eliminate the inclusion of these administrative costs in the determination of the medical loss ratio percentages. This finding is repeated from the previous examination report.

Management Comments

Management Concurs

D. Management Agreement

For the year ended December 31, 2013, UPRV reported total Administrative Expenses of $502,344,407 which included direct expenses incurred by UPRV and administrative and support services fees paid pursuant to the management agreement between UPRV and USCRV, the related party management company. Administrative Expenses represented 12.3% of total premium revenue. The administrative services agreement requires USCRV to perform certain administrative and support services necessary for the operation of UPRV for a fee based on (a) expenses for services or use of assets provided solely to the Company, and (b) the Company's allocated portion of expenses where the services or use of assets are shared among the Company and other Health Plans. These services include, but are not limited to, finance, management information systems, claim administration, telephonic member and provider services support, legal, regulatory, and provider credentialing. The fees paid to USCRV are based upon a cost allocation method consistent with NAIC Statement of Statutory Accounting Principles (SSAP) No. 70. SSAP 70 recognizes that an entity may operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.

Additionally, UPRV has entered into an administrative services agreement with United Behavioral Health (UBH) to provide mental health and substance abuse services paid on a per member per month rate. UBH is a related party to UPRV.

The management agreements were previously approved by TDCI and the TennCare Bureau. The allocation methodologies utilized by UPRV were reviewed by TDCI. No deficiencies were noted during the review of the management agreement.

E. Schedule of Examination Adjustments to Capital and Surplus

As result of the examination of TennCare operations, no adjustments are recommended to Capital and Surplus for the period ending December 31, 2013.

VI. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-126(b)(1) and Section 2.22.4 of the CRAs. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-126(b)(1) by testing monthly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of the statute. If a TennCare MCO fails to meet the prompt pay standards for any subsequent month after the month in which non-compliance was communicated by TDCI, the MCO will be penalized as allowed by the statute in an amount not to exceed ten thousand dollars ($10,000). The TennCare MCO is required to maintain compliance with prompt pay standards for 12 months after the month of failure to avoid the penalty.

Prompt Pay Results for All Claims Processed

The following table represents the results of prompt pay testing combined for all TennCare claims processed by UPRV and the vision claims subcontractor.

All TennCare Operations	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2013	100%	99.5%	Yes
February 2013	100%	99.9%	Yes
March 2013	100%	99.9%	Yes
April 2013	100%	99.8%	Yes
May 2013	100%	99.8%	Yes
June 2013	100%	99.9%	Yes
July 2013	100%	99.9%	Yes
August 2013	100%	100.0%	Yes
September 2013	100%	100.0%	Yes
October 2013	100%	100.0%	Yes
November 2013	100%	100.0%	Yes
December 2013	100%	100.0%	Yes

When combining the results for all claims processed, UPRV was in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2013. Additionally, the results of the prompt pay testing separately by region were in compliance with Tenn. Code Ann. § 56-32-126(b)(1) for all months in 2013.

Prompt Pay Results for Vision Claims

Separate testing of the claims processed by the vision subcontractor, March Vision, Inc., found that March Vision, Inc., processed claims timely for all months during the 2013 calendar year.

Prompt Pay Results for NEMT Claims

Pursuant to Section 2.22.4 of the CRAs, UPRV is required to comply with prompt pay claims processing requirements in accordance with Tenn. Code Ann. § 56-32-126. In addition, pursuant to ATTACHMENT XI Section A.15.3 and A.15.4 of the CRAs, UPRV is required separately to comply with the following prompt pay claims processing requirements for non-emergency transportation claims (NEMT):

- The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

- The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

Prompt pay testing by TDCI determined that the NEMT claims were processed in compliance with Section 2.22.4 of the CRAs for all months during the 2013 calendar year.

Prompt Pay Results for CHOICES Claims

Pursuant to Section 2.22.4 of the CRAs, UPRV is required to comply with the following prompt pay claims processing requirements for nursing facility claims and for Home and Community Based Services (HCBS) claims submitted electronically in a HIPAA-compliant format (CHOICES claims):

- Ninety percent (90%) of clean claims for nursing facility services and HCBS excluding PERS, assistive technology, minor home modifications, and pest control shall be processed and paid within fourteen (14) calendar days of receipt.

- Ninety-nine point five percent (99.5%) of clean claims for nursing facility and HCBS other than PERS [personal emergency response system], assistive technology, minor home modifications, and pest control shall be processed and paid within twenty-one (21) calendar days of receipt.

Prompt pay testing by TDCI determined that CHOICES claims were processed in compliance with Section 2.22.4 of the CRAs for all months during the 2013 calendar year.

The complete results of TDCI's prompt pay compliance testing can be found at http://www.tn.gov/tncoversight/promptpaybpm.shtml .

B. Determination of the Extent of Test Work on the Claims Processing System

Several factors were considered in determining the extent of testing to be performed on UPRV's claims processing system.

The following items were reviewed to determine the risk that UPRV had not properly processed claims:

- Prior examination findings related to claims processing,

- Complaints or independent reviews on file with TDCI related to inaccurate claims processing,
- Results of prompt pay testing by TDCI,
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau,
- Review of the preparation of the claims payment accuracy reports,
- Review of the results of monthly focused claims testing, and
- Review of internal controls related to claims processing.

As noted below, TDCI discovered deficiencies related to UPRV's claims payment accuracy testing and focused claims testing. A discussion of the sample selection methodology can be found in Sections VII.C and VII.D of this report.

C. Claims Payment Accuracy

1. Claims Payment Accuracy Reported (CPAR) by UPRV

Section 2.22.6 of the CRAs requires that 97% of claims are paid accurately upon initial submission. On a monthly basis, UPRV submits claims payment accuracy percentage reports to TennCare based upon audits conducted by UPRV. A minimum sample of one hundred and sixty (160) claims randomly selected from the entire population of electronic and paper claims processed or paid upon initial submission for the month tested is required. Additionally, each monthly sample of one hundred and sixty (160) claims shall contain a minimum of thirty (30) claims associated with nursing facility services provided to CHOICES members and thirty (30) claims associated with HCBS provided to CHOICES members. The testing attributes to be utilized by UPRV are defined in the CRAs between UPRV and the TennCare Bureau. Additionally, subcontractors responsible for processing claims shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

UPRV failed to achieve the contractual requirement of 97% claims payment accuracy during calendar year 2013 as follows:

Month of Filing	Region	Claim Type	Percentage Reported
September 2013	East Tennessee	Long-term Care	96%
October 2013	East Tennessee	Medical	96%
November 2013	Middle Tennessee	Long-term Care	95%
November 2013	West Tennessee	Long-term Care	93%

Management Comments

Management Concurs

2. Claims Payment Accuracy Reported by the Vision Subcontractor

UPRV contracts with March Vision, Inc., for the provision of vision services. March Vision reported claims payment accuracy percentages in compliance with the contractual requirement for all regions in calendar year 2013.

3. Claims Payment Accuracy Reported for NEMT

ATTACHMENT XI Section A.15.5 of the CRAs requires UPRV to pay 97% of NEMT claims accurately upon initial submission. Additionally, ATTACHMENT XI Section A.15.6 of the CRA requires an audit of NEMT claims that complies with the requirements in the CRA regarding a claims payment accuracy audit. UPRV reported compliance with the claims payment accuracy contractual requirement for all regions during calendar year 2013.

4. Procedures to Review the Claims Payment Accuracy Reports

The review of the claims payment accuracy reports included an interview with responsible staff of UPRV to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy reports. The review included verification that the number of claims selected by UPRV agreed to Section2.22.6 of the CRAs. These interviews were followed by a review of the supporting documentation used to prepare the December 2013 claims payment accuracy reports. From UPRV's December 2013 claims payment accuracy report, TDCI selected for verification 20 claims reported as accurately processed and the only medical claim reported as an error. Also TDCI selected for verification from the December 2013 NEMT claims payment accuracy report, five claims reported as accurately processed and the only two claims reported as errors. For claims that were reported as accurately processed by UPRV, TDCI tested the claims to the attributes requirements in Section 2.22.6.4 of the CRA. TDCI tested all three claims UPRV reported as errors focusing on the type of error (manual or system) and whether the claim had been reprocessed.

5. Results of the Review of the Claims Payment Accuracy Reporting

For the twenty claims reported as accurately processed by UPRV in the December 2013 claims payment accuracy report and selected for verification by TDCI, the following deficiency was noted:

- Section 2.22.6.4.5 of the CRAs requires UPRV to determine if the allowed payment agrees with the contracted rate. UPRV's claims payment accuracy testing procedures do not confirm the allowed payment to the amount defined in the providers' contract for each claim tested.

- For two of the twenty claims tested, the amount paid by UPRV could not be verified against the reimbursement terms of the provider agreements.

- For the twenty claims selected for testing, two paid claims were never submitted to TennCare as encounter data as required by Section 2.12.9.34.2 of the CRAs.

Management Comments

Management Concurs

For the three claims reported as errors by UPRV in the December 2013 claims payment accuracy report and selected for verification by TDCI, two were NEMT claims and one was a medical claim. All three claims that were identified as errors in the CPAR testing were adjusted appropriately.

D. Focused Claims Testing

Effective January 1, 2012, the CRAs include additional monthly focused claims testing requirements that require UPRV to self-test the accuracy of claims processing based on a sample of claims selected by TDCI. Unlike random sampling utilized in the claims payment accuracy reporting, the focused testing judgmentally selects a sample based on known claims processing issues or claims involving complex processing rules. Any results reported from focused testing are not intended to represent the percentage of compliance or noncompliance for the total population of claims processed by UPRV. The focused testing results highlights or identifies claims processing issues for improvement. For examination purposes, TDCI utilized the results of the focused claims testing to evaluate the accuracy of the claims processing system.

For monthly focused testing by UPRV during calendar year 2013, TDCI judgmentally selected 25 claims for each CRA from the data files submitted by UPRV for prompt pay testing purposes, resulting in a total of 75 claims selected for each month. The focused areas for testing during calendar year 2013 included the following:

- Paid and denied medical claims,
- Adjusted claims,
- Claims with processing lags over 60 days,
- Paid and denied CHOICES nursing facility claims,
- Paid and denied CHOICES HCBS claims,
- Claims processed by subcontractors, and
- Claims denied for exceeding timely filing limits.

1. Results of Focused Claims Testing

   Each month, TDCI provided UPRV with the claims selected for testing and specified the attributes for UPRV to self-test to determine if the claims were accurately processed. For the 900 claims tested for calendar year 2013, UPRV reported at least one attribute error on 91 claims. It should be noted that a claim may fail more than one attribute. For the 91 claims, 114 attribute errors were reported by UPRV. The following table summarizes the focused claims testing errors reported by UPRV for calendar year 2013:

Attribute Tested	Errors Reported by UPRV
Data Entry is Verified with Hardcopy Claim	1
Correct provider is Associated to the Claim	4
Authorization Requirements Properly Considered	16
Member Eligibility Correctly Considered	6
Payment Agrees to Provider Contracted Rate	6
TennCare Rate Reduction and Restorations Applied to Payment	0
Duplicate Payment Has Not Occurred	2
Denial Reason Communicated to Provider Appropriate	0
Copayment Correctly Considered	46
Modifier Codes Correctly Considered	0
Other Insurance Properly Considered	4
Patient Liability Correctly Applied	25
Coding-Bundling/Unbundling Properly Considered	2
Application of Benefit Limits Properly Considered	0
Considered Benefit Limit HCBS Provided as Cost Effective Alternative	0
Application of Expenditure Cap for Member in Group 3 Considered	0
Inappropriate Processing of an Adjusted Claim (June 2013)	2
Total	114

2. Significant System Issues Identified During Focused Testing

   A review of the claims noted as errors revealed both manual and system errors. The following is a discussion of significant claims system errors identified:

   a. UPRV indicated that two claims were incorrectly denied during the January 2013 focused testing for the same reason. UPRV noted for one claim the claim system was incorrectly applying claims coding billing rules and the system error had been fixed. For the other claim, UPRV indicated that additional research found that the initial response to the focused testing was incorrect. The claim had been correctly denied for claims coding rules.

b. UPRV indicated that three claims incorrectly denied for "submitted after provider's filing limit". The members were made retroactively eligible and the claims should have paid. UPRV indicated that the claims have been sent for adjustment.

During fieldwork UPRV provided the following response, "A claim can be denied for timely filing [if] the claim is not received within 120 days of the date of service. The claims payment system is unable to identify a retro eligible member from the claims submission unless the claim is marked 'retro eligible' in the remarks field of the claim. This notation will prompt the claims system to notify the examiner to verify retro eligible status. If determined that the member is retro eligible, timely filing is overridden as directed in the Claims Processing SOP."

c. UPRV indicated that one claim incorrectly denied with denial reason "Medicaid ID number/disclosure needed". UPRV indicated that there was a disclosure ID on file and the claim should have paid. The claim was sent for adjustment.

Management Comments

Management Concurs

3. Additional Items Noted by TDCI During Focused Claims Testing

TDCI noted the following additional issues as a result of focused claims testing:

a. Vague Denial Reasons

Multiple claims were denied with the only denial reason communicated to the provider is "claim lacks needed information" or "payment adjustment submission/billing error". These are vague denial explanations and do not provide enough information for the provider to correct the claim. This finding is repeated from the previous examination report.

b. Encounter Data Issues

- Compliancy Edit Failures:

Multiple paid claims were not submitted to TennCare since the claims failed compliancy edits. Encounter data for all paid claims should be submitted to TennCare.

After fieldwork, UPRV indicated that they have implemented a series of system enhancements intended to correct system errors related to

compliancy edits. The system enhancements are expected to be completed by the end of the first quarter 2015.

- Dual Eligible:

  Multiple claims were submitted with the prompt pay data file as denied claims and paid zero dollars; however, the explanation codes indicated that the charges have been paid by another payer or Medicare. The claims were not submitted to TennCare for encounter data. Claims that have been paid by another payer or Medicare should be reported as paid claims and submitted to TennCare as encounter data.

  UPRV submitted a corrective action plan as a result of the September 2013 testing stating that modifications have been made to reflect claims that have paid $0 to be reported as paid claims. TDCI noted that the modifications were completed in the November 2013 prompt pay submission.

c. Significant claims adjudication issues related to CHOICES claims submitted via the separate Electronic Visit Verification system (EVV) were noted by TDCI during the review of UPRV's monthly focused claims testing. The following system issues were noted:

   - UPRV communicates the procedure code and the modifier to the EVV system based upon the enrollee's plan of care. The provider has the ability to change the modifier in the EVV system and therefore perform a service not authorized in the enrollee's plan of care.

   - The authorizations granted in UPRV's claims processing system are not always in agreement with the authorizations loaded in the EVV system. The plan indicated that duplicate authorizations may be loaded into the EVV system instead of being replaced by updated authorizations in the EVV system causing billing errors. As a result of the error, providers are able to provide and bill for services not in agreement with the enrollee's plan of care.

   - For Home and Community Based Services (HCBS) claims, UPRV routinely communicates a second denial reason or explanation to the provider "claim may be covered by COB". This is not an appropriate denial reason since CHOICES HCBS claims would never be covered by other insurance. UPRV indicated that other insurance typically does not cover these services once a member has CHOICES services.

   - In completing the attribute test work for the monthly focused claims testing, UPRV indicated adjustments were required on several claims: however, UPRV did not indicate any errors were noted in any of the tested attributes. If processing adjustments are required on a claim that

was tested, at least one attribute should be answered “No”. UPRV should more carefully review responses to monthly focused claims testing results to ensure they are accurate before submitting them to TDCI.

UPRV and/or its subcontractor’s should establish controls that require providers to perform services only authorized by the enrollee in his/her plan of care. Relevant CRA requirements of the EVV system include section 2.9.6.12.5.4 which states, "The ability to match services provided to a member with services authorized in the plan of care;" and Section 2.9.6.12.5.5 which states, "The ability to ensure that the provider/worker delivering the service is authorized to deliver such services."

Management Comments

Management Concurs

d. Prompt Pay Submission Issues

TDCI noted the following issues in relation to the accuracy of the prompt pay data file submissions from which the samples of claims for focused testing were selected:

- Multiple claims were submitted with a status of “denied” and zero dollars paid; however, the explanation code indicated that the charges have been paid by another payer. UPRV should have marked these as “paid” claims even though there was no UPRV liability after the primary insurer paid.

- Multiple claims were incorrectly reported as “paid” or “denied” rather thanas “adjusted”. UPRV agreed that the claims should have been reported as “adjusted”. UPRV stated, “Due to our logic hierarchy we occasionally have claims that are tagged as paid or denied rather than adjusted. The prompt pay logic is under review and the hierarchy is part of that review, but changes have not been implemented yet.” UPRV further indicated that there is a manual process that went into place with the October 2013 prompt pay submission. Additionally, UPRV stated that the date for the system correction of this prompt pay reporting issue had not been determined.

Management Comments

Management Concurs

e. Eligibility Determination

Multiple claims were denied for “date of service after the subscriber termination”. UPRV’s claim system assigns a new member number any time

a member is reassigned to another Grand Region. The denial reason is inaccurate as the member was never terminated as a TennCare enrollee.

Management Comments

Management Concurs

f. Timely Filing

Testing resubmitted claims that were denied for timely filing found that the original claims were denied for missing Medicaid ID/TennCare disclosure. UPRV indicated that, per timely filing standard operating procedures (SOP), if a claim was originally denied for this reason, the timely filing requirement can be overridden when the claim is resubmitted after the appropriate disclosure is made. In violation of UPRV's SOP, the claims tested had continued to be denied in error for exceeding the timely filing limit.

Management Comments

Management Concurs

g. Vision Claims

TDCI judgmentally selected a sample 75 vision claims (25 claims for each Grand Region) for the March 2013 focused claims testing. It was noted there was at least one line on every claim that was denied and paid zero dollars. None of the lines that were denied were submitted to TennCare as encounter data. UPRV indicated that March Vision's "review revealed that all service lines with a zero paid amount were inadvertently excluded from encounter file." UPRV further indicated that March Vision is working with UPRV to submit historical data. Current data file submissions contain all service lines.

Management Comments

Management Concurs. UPRV worked with MARCH Vision Care to correct this deficiency and, beginning May, 2013, MARCH Vision Care's encounter submissions include zero dollar claim paid amounts. In addition, MARCH Vision Care has submitted the historical encounters for zero dollar claim paid amounts prior to May, 2013 to address the matter. This activity was completed in June, 2013.

4. Verification of UPRV's Self-reported Focused Testing Results

TDCI performed the following procedures to verify the accuracy of UPRV's self-reported focused testing results:

- Reviewed a judgmentally selected sample of 35 claims for which no errors were reported by UPRV, and

- Reviewed all 91 claims reported by UPRV as errors.

a. TDCI noted during the review of the procedures utilized by UPRV when testing the attribute, "Payment agrees to provider contracted rate", UPRV does not verify the claim pricing accuracy with payment terms in the executed provider contract.

Management Comments

Management Concurs

b. During the review of the 35 claims for which no errors were reported by UPRV,

TDCI could not verify that one claim paid at the correct reimbursement rate because the executed provider agreement could not be located.

Management Comments

Management Concurs

c. During the review of the 91 claims reported by UPRV to have processing errors, TDCI found that 38 of the 91 claims were never reprocessed to correct the errors. UPRV provided the following explanations during fieldwork as to why these claims were not reprocessed:

- UPRV later determined that 24 claims noted as processed in error were in fact processed correctly.

- Five claims were not reprocessed because there was either no financial impact or the financial impact was immaterial. As a result, the processing errors were not corrected.

- Nine claims had not been corrected at the time of fieldwork even though UPRV indicated that these claims should have been reprocessed.

UPRV should more carefully review responses to monthly focused claims testing results prior to the submission of the report to TDCI. Claims found to be processed in error should be promptly corrected.

Management Comments

Management Concurs

E. Copayment Testing

The purpose of copayment testing is to determine whether copayments have been properly applied for enrollees subject to out-of-pocket payments.

TDCI requested from UPRV a listing of the 100 enrollees with the highest accumulated copayments for the period January 1, 2013 through December 31, 2013. From the listing, five enrollees were judgmentally selected and all of the claims processed for those enrollees in calendar year 2013 were analyzed to determine if UPRV had correctly applied copayment requirements of the CRAs based on the enrollee's eligibility status. The test work revealed UPRV incorrectly applied a $500 copayment liability to one member. Based on the member's TennCare eligibility status no copayment should have been applied. The incorrect copayment in this instance was a manual adjudication error versus a claim processing system issue.

Management Comments

Management Concurs

F. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. TDCI selected twenty-five claims for remittance advice testing and no discrepancies were noted.

G. Analysis of Cancelled Checks/Electronic Funds Transfer (EFT)

The purpose of analyzing cancelled checks and EFTs is to: (1) verify the actual payment of claims by UPRV; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

TDCI requested UPRV to provide ten cancelled checks or EFT documentation related to claims previously tested by TDCI. UPRV provided the cancelled checks or the proof of EFT. The documents provided agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

H. Pended and Unpaid Claims Testing

The purpose of analyzing pended and unpaid claims inventories is to determine if a significant number of claims are unprocessed as of the financial statement date of December 31, 2013.

The pended and unpaid data files combined for East, Middle, and West Tennessee TennCare claims received by UPRV and UPRV's subcontractors that were submitted to TDCI for monthly prompt payment testing were reviewed. Pended and unpaid

claims inventory as of December 31, 2013, was similar to inventory levels for the previous three months. Of the total pended and unpaid claims of 53,813, a total of 80 claims were more than 60 days old as of December 31, 2013. It was determined that a significant number of unprocessed claims did not exist as of December 31, 2013.

I. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if UPRV's procedures ensure that all claims received from providers are either returned to the provider when appropriate or are processed by the claims processing system.

The mailroom function is subcontracted to Firstsource Solutions USA, Inc. (Firstsource). Firstsource's office in Kingston, New York, receives, sorts, scans, enters data, and reconciles all medical claims and correspondence received from UPRV providers and members. TDCI did not perform a site visit of the mailroom operations during this examination. UPRV provided responses to internal control questionnaires, flowcharts, and claims inventory reconciliation reports regarding mailroom operation. No additional test work of mailroom procedures was performed. No reportable deficiencies were noted by TDCI during the review of the mailroom and claim inventory controls.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints Received by UPRV

Provider complaints were tested to determine if UPRV responded to all provider complaints in a timely manner. Tenn. Code Ann. § 56-32-126(b)(2)(A) states in part:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

UPRV's policies and procedures state, "The Health Plan will respond in writing to such provider written reconsiderations within 30 days." Adherence by UPRV to this policy should ensure compliance with Tenn. Code Ann. § 56-32-126(b)(2)(A).

TDCI selected 10 provider complaints from UPRV's claims appeal (complaint) log for December 2013 to verify the timeliness of provider complaint processing. It was noted that one provider complaint was not resolved until 127 calendar days after receipt. UPRV did not have a written agreement with the provider that the resolution of this complaint would take longer than 60 days to complete in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A).

Management Comments

Management Concurs

B. Provider Complaints Received by TDCI

TDCI offers to providers a complaint process for resolving disputes with TennCare MCOs. Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCO, miscommunication or confusion around MCO policy and procedures, etc. When a provider complaint is received, TDCI forwards the complaint to the MCO for investigation. The MCO is required to respond in writing within 14 days to both the provider and TDCI to avoid assessment of liquidated damages pursuant to the "On Request" report requirements of the CRAs. If the provider is not satisfied with the MCO's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an independent reviewer for resolution or pursuing other available legal or contractual remedies.

For the period January 1 through December 31, 2013, TDCI received and processed 467 provider complaints against UPRV. The responses by UPRV to providers were categorized by TDCI in the following manner:

Previous denial or payment upheld	237
Previous denial or underpayment reversed in favor of the provider	178
Previous denial or underpayment partially reversed in favor of the provider	22
Provider complaint ineligible	1
Other Inquiries	25
Provider complaint withdrawn by provider	3
Duplicate complaint	1

TDCI judgmentally selected ten UPRV provider complaints submitted to TDCI for review. The issues raised by the providers were analyzed and questions were posed to UPRV for response. Emphasis was placed on discovering deficiencies in the

UPRV's claims processing system or provider complaint procedures. No reportable issues were noted by TDCI in the claims processing system or provider complaint procedures.

C. Independent Reviews

The independent review process was established by Tennessee Code Ann. § 56-32-126(b)(2) to resolve claims disputes when a provider believes a TennCare MCO has partially or totally denied claims incorrectly. TDCI administers the independent review process, but does not perform the independent review of the disputed claims. When a request for independent review is received, TDCI determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCC's first denied the claims). If the claims are eligible, TDCI forwards the claims to a reviewer that is not a state employee or contractor and is independent of the MCC and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

For the period January 1 through December 31, 2013, 277 independent reviews were initiated by providers against UPRV. The following is a summary of the reviewer decisions:

Reviewer decision in favor of the provider	36
Reviewer decision in favor of UPRV	139
Reviewer decision in favor of UPRV in part and provider in part	25
Settled for provider	38
Settled in favor of UPRV in part and provider in part	1
Request submitted by provider was ineligible	35
Request withdrawn by provider	3

TDCI judgmentally selected 5 independent reviews, analyzed the issues raised by the provider, and posed questions to UPRV for response. Emphasis was placed on discovering deficiencies in the UPRV's claims processing system, provider complaint procedures and independent review procedures. No reportable issues were noted by TDCI in the claims processing system or the provider complaint and independent review procedures.

D. Provider Manual

The provider manual outlines written guidelines for providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

On November 29, 2013, UPRV submitted for prior approval an update to the provider manual. After UPRV corrected noted deficiencies, the update was approved by TDCI on January 15, 2014.

E. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-103(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, Section 2.12.2 of the CRAs requires all template provider agreements and revisions thereto to be approved in advance by TDCI, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Furthermore, Section 2.12.7 of the CRAs sets forth the minimum language requirements for provider agreements.

Five executed provider agreements were judgmentally selected for testing. Two of the five executed agreements were not based on templates prior approved by TDCI. These provider agreements had been submitted to and disapproved by TDCI. UPRV should not execute provider agreements on templates not approved by TDCI in violation of TCA § 56-32-103 and CRA section 2.12.2.

Management Comment

Management Concurs

UPRV resubmitted one of the two executed provider agreements not based on prior approved templates; however, TDCI again disapproved it because it failed to meet CRA provider agreement requirements. UPRV has not resubmitted the agreement to TDCI for approval.

Management Comment

Management Concurs

F. Provider Payments

Capitation payments made to providers during 2013 were tested to determine if UPRV complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per the provider contract requirements.

G. Subcontracts

HMOs are required to file notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-103(c)(1). Additionally, per Section 2.26.3 of the CRAs, all subcontractor agreements and revisions thereto must be approved in advance in writing by TDCIand the TennCare Bureau in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof.

Six subcontract agreements were tested to determine the following: (1) that the contract templates were prior approved by TDCI and the TennCare Bureau and (2) that the executed agreements were on approved templates.

1. For one of the six subcontracts tested, the template was submitted by UPRV and prior approved by TDCI; however, UPRV executed the subcontract on a version that was not approved by TDCI. The executed version of the subcontract was never submitted to TDCI for prior approval.

2. For one of the six subcontracts tested, TDCI noted that the subcontractor, a UPRV affiliate, further subcontracted with an additional company to perform subrogation services. The entity performed data mining services. The UPRV affiliate did not receive prior written approval from UPRV before entering into the subcontract. Execution of the subcontract for data mining services violated the following:

   - Section 2.26.2 of the CRA requires UPRV to ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor without prior written approval of UPRV.

   - Section 2.26.3 of the CRA requires all subcontracts be approved in advance in writing by the TennCare Bureau.

   - Section 2.26.1.4 of the CRA requires UPRV to monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis consistent with NCQA Standards and state MCO laws and regulations.

Management Comments

Management Concurs

H. Non-discrimination

Section 2.28 of the CRAs requires UPRV to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the

Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UPRV staff and a review of policies and related supporting documentation, UPRV was in compliance with the reporting requirements of Section 2.28 of the CRAs.

I. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

The Internal Audit Department of UPRV's parent company, UnitedHealth Group, performs internal audits specific to the TennCare plan. The results of the specific reviews by the Internal Audit Department were considered by TDCI during the current examination. The report included findings and responses through Agreed-Upon Action Plans by UPRV's management. The findings were considered by TDCI during the current examination. TDCI notes that continued internal audits of TennCare CRA requirements have been scheduled.

As previously noted, Section 2.22.6.2 of the CRAs requires the claims payment accuracy reports be prepared by the plan's Internal Audit Department. The reports are not prepared by UPRV's Internal Audit Department but rather by a Quality Assurance Unit within UPRV's Claims Operations Department. The Bureau of TennCare granted a deviation to this CRA requirement to permit staff other than UPRV's Internal Audit Department to prepare the claims payment accuracy reports.

J. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986 (Act). Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…." UPRV is domiciled in the State of Illinois. TDCI interprets the Act as applying to foreign health maintenance organizations in a manner that treats such foreign entities as a domestic insurer for the purposes of being regulated under the Act. Through a Memorandum of Understanding executed January 14, 2013, UPRV agreed to TDCI's interpretation and consented to be regulated as a domestic insurer under the Act. The review of the annual filing for Illinois is required to also be

submitted to TDCI. No discrepancies were noted in the annual holding company registration filing received in 2014 for the calendar year 2013.

K. Health Insurance Portability and Accountability Act (HIPAA)

Section 2.27 of the CRAs requires UPRV to comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to, the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations.

UPRV's information systems policies and procedures were reviewed in relation to the HIPAA requirements of the CRAs. No deficiencies were noted during the review of policies and procedures related to HIPAA requirements.

L. Conflict of Interest

Section 4.19 of the CRAs warrant that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UPRV in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRAs were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRAs shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of the CRA's conflict of interest clauses in all subcontracts, provider agreements and any and all agreements that result from the CRAs.

Testing of conflict of interest requirements of the CRAs noted the following:

- The most recently approved provider agreement templates contain the conflict of interest language of the CRAs.

- The organizational structure of UPRV includes a compliance officer who reports to the CEO for TennCare operations.

- UPRV has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- The policies indicate all business associates are to comply with UPRV's conflict policy.
- Employees complete conflict of interest certificates of compliance annually per the written policies and procedures.
- Internal audits are performed and include steps to determine compliance with the conflict of interest requirements of the TennCare CRAs.

TDCI noted no material instances of non-compliance with conflict of interest requirements during the examination test work.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of UPRV.

Appendix

Previous Examination Findings

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by TDCI for the period January 1 through December 31, 2011.

A. Financial Deficiency

1. Administrative costs are incorrectly reported as medical costs in the determination of medical loss percentages.

2. Credit balances due to UPRV from medical providers were exchanged for the reduction of inter-company payables with USCRV. USCRV assumed responsibility for the collection of the provider credit balances. However, transfer of this asset in this manner was not defined in the management agreement between UPRV and USCRV.

The prior financial deficiency number 1 has been repeated in this report.

B. Claims Processing Deficiencies

1. UPRV was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) for all claims processed and claims processed in each of the three Grand Regions for the month of January 2011. The processing of vision claims was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) in the East Tennessee Grand Region for the month of November 2011. The processing of non-emergency medical transportation claims was not in compliance with prompt pay claims processing requirements of Tenn. Code Ann. § 56-32-126(b)(1) in each of the three Grand Regions for the month of January 2011.

2. UPRV was not in compliance with the CHOICES prompt pay claims processing requirements of Section 2.22.4 of the CRAs for the months of January, June, and July 2011 in the Middle Tennessee Grand Region and January and July 2011 in the West Tennessee Grand Region.

3. UPRV was not in compliance with Section 2.22.6 of the CRAs requirement that 97% of claims are paid accurately upon initial submission for the months of January, March, May and June 2011 for medical claims; February, March, April, May, and June 2011 for nursing facility claims; and March and April 2011 for Home Community-Based Community Services claims.

4. Significant deficiencies were noted in UPRV's testing procedures and reporting for non-emergency transportation (NEMT) claims payment accuracy. UPRV's

non-emergency medical transportation claim payment accuracy report testing was not performed in accordance with CRA requirements. UPRV did not select a sample from all processed and paid NEMT claims; instead, UPRV incorrectly included only adjusted claims in the population when selecting the NEMT claims to be tested. Also, the error rate reported on the fourth quarter 2011 NEMT Claims Payment Accuracy Report was not calculated properly.

5. Verification by TDCI of the claims payment accuracy report submitted by UPRV for December 2011 indicated the following deficiencies:

    - One claim determined as an error by UPRV in January 2012 was not adjusted by UPRV until October 2, 2012.

    - One claim did not pay according to the contracted rate noted in the agreement between the medical provider and UPRV. UPRV indicated that only a subsample of claims is verified against allowed payment rates in the provider agreements. UPRV should update procedures to verify that the allowed payment rate agrees to the terms of the provider agreement for all claims selected for testing.

6. Comparison of the actual claim date with the claims processing system data indicated that for one of 75 claims selected for focused claims testing, the date of service was incorrectly entered by UPRV into the claims processing system.

7. The following adjudication accuracy errors were noted by UPRV in the 75 claims selected for focused testing of claims processed in December 2011:

    - One medical claim was incorrectly denied with the explanation Medicaid identification and disclosure needed. The effective date of the Medicaid identification and disclosure was available to UPRV.

    - One NEMT claim was incorrectly denied for missing or invalid National Provider Identification (NPI) number. The reported NPI number by the provider was valid.

    - One NEMT claim was incorrectly denied with the explanation that the claim may be covered by coordination of benefits. Additionally, this error was identified by UPRV in February 2012 but the claim had not been adjusted by October 1, 2012.

    - One NEMT claim was incorrectly denied with the explanation that the claim was a duplicate of a previously submitted claim. The claim was not a duplicate since the provider billed an additional modifier to the procedure code.

    - One NEMT claim denied with the explanation “payment adjustment submission/billing error”. The denial reason communicated to the provider is

vague and does not provide enough information for the provider to correct the claim.

8. The following additional issues were noted by TDCI in the verification of adjudication accuracy in the 75 claims selected for focused testing of claims processed in December 2011:

   - For one CHOICES claim and one NEMT claim, UPRV denied service lines for ineligibility even though the enrollees were eligible on the dates of service. Instead, the enrollees had been transferred to another Grand Region.

   - One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for absence of a prior authorization. A service was authorized by UPRV for the date of service; however, the provider billed a different service through the addition of a modifier to the procedure code. Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

   - One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for invalid bill type. The provider was able to perform a service not prior authorized by the enrollee in his/her plan of care. Other than the denial of the claim by UPRV's claims processing system, no evidence was noted by TDCI that the claims denials resulted in additional actions by care coordinators such as contacting the provider to discover why provider was performing services not authorized in the enrollee's plan of care.

   - One CHOICES claim billed by the provider through the electronic visit verification system was correctly denied by UPRV for benefit maximum reached. A comparison of the number of authorizations loaded in UPRV's claims processing system was fewer than the number of authorizations loaded in the separate EVV system. As a result, the provider was able to perform services not authorized by UPRV or by the enrollee in his/her plan of care because of the incorrect authorization counts in the EVV system.

9. For two of the five enrollees selected for copayment testing, UPRV incorrectly applied copayments when the enrollee was not subject to copayment requirements.

10. Review of mailroom inventory controls noted that the inventory reconciliation work sheets are not updated to reflect the disposition of all claims received daily

in the mail including claims that are initially rejected but later rescanned and entered electronically.

11. The following deficiencies were noted in the review of reimbursement changes as the result of the State of Tennessee budget requirements effective July 1, 2011.

    For emergency department professional fees to be capped at $50 for non-emergency claims:

    - For eight of the 146 claims selected for testing, UPRV incorrectly paid over $50 when neither the first or second diagnosis was considered emergent.

    - For one of the 146 claims selected for testing, UPRV incorrectly paid $50; however, the first and second diagnoses were considered emergent. The provider's contracted rate is greater than $50.

    For the 50 normal delivery exception claims selected for testing for the 17% rate increase, TDCI noted the following:

    - 19 claims remain incorrectly paid as of October 5, 2012,

    - TDCI noted that 28 different providers represented the 50 normal delivery exception claims selected for testing by TDCI. The configuration on 10 of these providers has not been corrected to reflect the reimbursement changes for dates of service on or after July 1, 2011.

    For the 56 Caesarean reimbursement exception claims selected for testing to be paid at the normal delivery rate, TDCI noted the following:

    - 10 claims remain incorrectly paid as of October 5, 2012,

    TDCI noted that 22 different providers represented the 56 Caesarean reimbursement exception claims selected for testing by TDCI. The configuration on 4 of these providers has not been corrected to reflect the reimbursement changes for Caesarean deliveries for dates of service on or after July 1, 2011.

The prior claims processing deficiencies 3, 5, 7, 8, and 9 have been repeated in similar findings in the current report.

C. Compliance Deficiencies

1. For the test month of December 2011, the following deficiencies were noted in review of the provider appeal complaint log.

    - In violation of Tenn. Code Ann. § 56-32-126(b)(2)(A), there were 2,380 provider appeals that were not responded to within the 30-day deadline and

there was no acknowledgement communicated to the provider that a response would exceed 30 days.

- A total of 601 complaints exceeded 60 days. No agreement was made in writing with the provider noting that the response would exceed 60 days in violation of Tenn. Code Ann. § 56-32-126(b)(2)(A).

2. A review of 11 complaints received by TDCI against UPRV noted the following areas where improvements should be made to UPRV's claims processing systems and the provider complaint procedures:

   - UPRV's claims processing procedures should include an active search for retroactive eligibility to prevent some claims being denied incorrectly for exceeding timely filing limits.

   - UPRV should ensure that first level responses to providers are accurate. Personnel responding to provider complaints should receive the proper training or relay the complaint to others in the organization if it is beyond their skill set.

3. A review of 5 independent review decisions made in favor of the provider noted the following area where improvements should be made to UPRV's processes for managing independent reviews:

   - UPRV did not send payment in full to the provider within twenty calendar days upon receipt of the reviewer's decision pursuant to Tenn. Code Ann. § 56-32-126(b)(3)(C). A decision was rendered by the independent reviewer on December 7, 2011. The claim had not been adjusted for payment as of October 1, 2012.

4. UPRV's process for submitting material modifications of it provider manual to TDCI for prior approval should be improved to promptly and accurately correct all deficiencies noted by TDCI.

5. A subcontract for an emergency room diversion program was executed on April 1, 2011; however this subcontract was not approved by TDCI until June 9, 2011.

6. UPRV's information systems policies and procedures did not include specific requirements for personnel to contact the TennCare privacy officer within two business days of any unauthorized use or disclosure of enrollee protected health information not otherwise permitted or required by HIPAA per section 2.27.2.13.3 or the CRAs for the East, Middle and West Tennessee Grand Regions.

The prior compliance deficiencies numbers 1, 2, and 5 are repeated in similar findings in the compliance section of the current report.